

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/03/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State hospital complaint.</p> <p>Complaint Number: IN00136195</p> <p>Substantiated; no deficiencies related to allegations are cited</p> <p>Facility Number: 005079</p> <p>Date: 10/3/13</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>Indiana University Health Ball Memorial Hospital is in compliance with 410 IAC 15-1.6.2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 10/24/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE